Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR STEVEN J THORNTON
8210 WALNUT HILL LANE SUITE 130
DALLAS TX 75231

Respondent Name
WAL MART ASSOCIATES INC

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-13-1227-01

MFDR Date Received
JANUARY 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per ARCMI 29822 is global to 29827 in which I provided the AAOS global data, CCI edit, and the operative report showing the debridement was of the glenohumeral joint, therefore a 59 modifier was added."

Amount in Dispute: $411.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "29822 CORRECTLY DENIED FOR REIMBURSEMENT IN ACCORDANCE WITH NCCI EDITS, WITH MODIFER 59 EXCEPTION NOT SUPPORTED."

Response Submitted by: Hoffman Kelley/Claims Management Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 12, 2012	CPT Code 29822-59	$411.36	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 899-In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) Component codes of comprehensive surgery: musculoskeletal system procedure (20000-29999)

has been disallowed.

- 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- W1-Workers compensation state fee schedule adjustment.
- 5036-Complex bill-review by medical cost analysis team.

Issues

1. Is the requestor entitled to reimbursement for CPT code 29822-59?

Findings

1. CPT code 29822 is defined as "Arthroscopy, shoulder, surgical, debridement, limited."

   The respondent denied reimbursement for CPT code 29822-59 based upon EOB denial reason codes "97 and 899."

   On the disputed date of service the requestor billed CPT codes 29827, 29822-59, 29826 and L3675.

   Per NCCI edits CPT code 29822 is a component of CPT code 29827; however, a modifier is allowed to differentiate the service.

   A review of the requestor's billing finds that the requestor appended modifier "59" to CPT code 29822.

   Modifier 59's descriptor is "**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-Evaluation and Management (E/M) services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used."

   The February 1, 2012 Operative report indicates that the claimant underwent "Right arthroscopic rotator cuff repair; Right arthroscopic subacromial decompression; and Right arthroscopic limited debridement of the glenohumeral joint including synovitis in anterior and superior compartment."

   The requestor did not support that CPT code 29822 was performed in "a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual;" therefore, per NCCI edits, code 29822 is a component of code 29827. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/22/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.